Department of Defense Nonappropriated Fund Health Benefits Program (DOD) Group Health Benefits Continuation Application

Employer Section (Please provide the following information necessary to ensure proper processing of application.)

1. To: Eligible Continuee Applicant's Name	2. From: Employer
	DEPARTMENT OF DEFENSE (DOD NAF HBP)

3. Address			
4. City		5. State	6. Zip Code
7. Suffix	Account / Plan		8. Date Applicant's Group Insurance Terminates
Employer's Authorized Signature (*PEOPLE Resource Office*)			Date

Continuation of Group Health coverage is available to you due to the following:

☐ 1. The employee's termination of employment (includes retirement or layoff) or loss of eligibility due to reduction in hours on _____.
☐ 2. The employee's death on _____.
☐ 3. The employee's divorce or legal separation effective _____ .
☐ 4. A dependent child has ceased to be an eligible dependent (e.g. has reached limiting eligibility age under the Group Health Policy) as of _____.
☐ 5. Loss of dependent coverage because employee was enrolled for Medicare benefits on _____.

The Group Health coverage under which you have been covered will cease because of the reason and on the date indicated above unless you comply with requirements that follow:

Prior to _____ (which is 45 days after the date coverage ceases, you must complete the Direct Billing Enrollment Request below if you want continuation. Return it to the address on the reverse side of this form along with your check to cover the initial payment.

THE CHECK FOR THIS INITIAL PAYMENT MUST COVER THE NUMBER OF FULL MONTHS FROM THE ABOVE INSURANCE TERMINATION DATE TO THE TIME OF YOUR ELECTION.

Coverage Available: Medical

The initial monthly cost for Continued Group Health Coverage is: Single $ _____ Family $ _____

NOTE: Rates are subject to audit by Aetna US Healthcare or Department of Defense. (Any adjustments in premium will be reflected on your next monthly statement.)

After the initial payment, you must submit the same monthly payment as billed, until you have been advised of a general change for all participants. If you fail to make the billed monthly payment within 31 days of its due date, your coverage will cease on that date and cannot be reinstated.

Make Check Payable To: AETNA LIFE INS. CO.

IF YOU RESPOND IMMEDIATELY, YOU WILL ASSURE EARLY REINSTATEMENT OF COVERAGE AND MINIMIZE CLAIM DELAY.

Direct Billing Enrollment Information — Must Be Completed

Applicant Section - (See Reverse Side For Instructions as to Information Requested in Items 1-8 Below, and Mailing Instructions**)**

1. Applicant's Name (Last, First, Middle Initial)	2. Applicant's Social Security Number	3. Employee's Social Security Number (If Applicant is Other than Terminated Employee)

4. Applicant's Date of Birth *(MM/DD/YYYY)*	5. Applicant's Address (Street, City, State, Zip Code)	6. Telephone Number ( )

7. Coverage is for:

☐ **Single**
- ☐ Self Only
- ☐ Spouse Only
- ☐ Child Only

☐ **Family**
- ☐ Self & Spouse
- ☐ Self & Child/Children
- ☐ Spouse & Child/Children
- ☐ Self, Spouse & Child/Children

If you or any of your dependents are covered under another Group Health Plan, please indicate Type of Coverage, Health Plan Sponsor and Family Members Covered.

_____

_____

_____

Complete only if you are enrolling in Managed Choice.

8.					Managed Choice Network ID #	
	Name (First, Middle Initial, Last)	Social Security Number	Rel. Code*	Birthdate MM / DD /YYYY	Primary Care Provider Name Primary Care Provide r Number**	Prev. Seen Y or N
Employee			**Self**		Name No.	
Dependent					Name No.	
Dependent					Name No.	
Dependent					Name No.	
Dependent					Name No.	
Dependent					Name No.	

** Relationship Codes: Husband (H); Wife (W); Son (S); Daughter (D); Sponsored Male Child (Y); Sponsored Female Child (X)*
*** Please refer to your Managed Choice Directory to select your Primary Care Physician (PCP) and PCP identification number.*

A check to cover the number of months from the date of Group Insurance Termination should accompany this enrollment.

Part 1 Aetna Special Plans Department
Part 2 Applicant Copy/Retain for Your Records
Part 3 Policyholder's Copy- Employee's OPF
Part 4 Claim Copy-Submit with Part 1

Applicant's Signature (Required)	Date

If you make the monthly payment(s) as indicated, your group health coverage will be continued for up to:

- 18 months following termination of employee's employment or lost eligibility due to reduction in hours.
- 18 months following the date of the employee's death, divorce, legal separation, or dependent child's ineligibility. If any of these events occur during the employee's 18 month continuation period, then non-employee beneficiaries who were continuously eligible from the qualifying event may continue for up to 18 months from the date of the employee's original termination date.
- The date on which the DOD NAF HBP ceases to provide any employee health coverage. (However, if health coverage is replaced, further continuation will be provided under the terms of any succeeding arrangement.)
- **The date following your termination date on which you are or become covered under another group health pan or enrolled in Medicare.**

Medical Conversion Option (Available for Aetna provided Medical Coverages only)

In the event you do not elect continuation in the first place or if any continuation ceases because of the 18 month limit, you may apply for conversion of your Group Medical Expense Benefits to an individual policy, without medical examination, subject to the same conversion privilege which applies under the group plan. If you wish to be insured under an individual medical conversion policy, you must exercise your conversion privilege within 31 days after continuation ceases or within the time period required under the group plan. You may insure yourself alone or yourself and all dependents who are covered at that time.

You may complete and submit the conversion application anytime within 180 days prior to the end of the 18 month continuation period, the conversion policy cannot become effective until the day following the date on which the above maximum period ends.

If you are interested in taking advantage of this conversion privilege or receiving more details, please write to: (**This will be your only notification of this option.**)

Aetna Life Insurance Company
Aetna Health Plans - Conversion Unit
P.O. Box 2117
Fall River, MA 02722-2117

Applicant's Instructions for Completion of Direct Billing Enrollment Information

To be completed **by the former employee** if block 1 is checked; **by the spouse** if block 2, 3, or 5 is checked; and **by the former dependent child** if block 4 is checked.

Item No. 1	Please complete your name: (Last, First & Middle Initial).
Item No. 2	Fill in your Social Security Number.
Item No. 3	Fill in the Social Security Number of the employee who originally held the coverage under the group. This should be completed for all applicants other than the terminated employee.
Item No. 4	Your Date of Birth.
Item No. 5	Complete your full address.
Item No. 6	Fill in a telephone number where you can be contacted.
Item No. 7	Check off either block to advise of any dependent coverage information. Enrollment coverages will be the same for all family members unless a separate request form is furnished.
Item No. 8	List applicant's eligible dependents to be covered under this application. If you live in a Managed Choice network area, your medical plan option is Managed Choice. If enrolling in Managed Choice, complete the Primary Care Physician information and network ID #. The network ID # appears on the front page of your Managed Choice directory.

The Names, Relationship and Date of Birth of all eligible dependents should be listed. These dependents must have been previously covered under the group.

Sign and date the form. Retain the "Applicant's Copy" and send the two remaining copies, along with a check* for the coverage period to date, to:

Special Plans – Direct Billing Unit
151 Farmington Avenue – MB1K
Hartford, CT 06156

***REMINDER: THE CHECK FOR THIS INITIAL PAYMENT MUST COVER THE NUMBER OF FULL MONTHS FROM THE INSURANCE TERMINATION DATE TO THE TIME OF YOUR ELECTION.**

Participant's Ongoing Responsibilities

- Remit monthly premiums to the Direct Billing Unit by the due date.
- Submit claims in the normal fashion to the Claim Benefit Payment Office.
- Notify Direct Billing Unit of Changes in dependent status (provide proof).
- Notify Direct Billing Unit of Name and Address Changes.
- Report acquisition of any other group health coverage.